Save Print Reset

MAILING ADDRESS:
STATE BOARD OF NURSING
PO BOX 656
JEFFERSON CITY MO 65102-0656
(573) 751-0073
Email: nursingpractice@pr.mo.gov
Website: http://pr.mo.gov/nursing.asp

DELIVERY ADDRESS
3605 MISSOURI BOULEVARD
JEFFERSON CITY, MO 65109

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

ADVANCED PRACTICE REGISTERED NURSE APPLICATION

FOR OFFICE USE ONLY

APPROVED	APP DATE	DENIED	CRT
GRAD APP	GRAD APP DATE	GRAD EXP	GRAD CRT
CASH	MO	CHECK	DEPOSITED

SEE INSTRUCTIONS LETTER BEFORE COMPLETING THIS APPLICATION

APPLICATION FEE IS NON-REFUNDABLE. APPLICATION IS VOID IF REQUIREMENTS FOR RECOGNITION ARE NOT MET WITHIN ONE YEAR YOU MUST HAVE A CURRENT RN LICENSE FROM EITHER MISSOURI OR ANOTHER COMPACT STATE IN ORDER TO BE RECOGNIZED AS AN APRN IN MISSOURI.

SECTION I - PROFILE INFORMATION — ALL APPLICANTS

1. FULL NAME (LAST, FIRST, MIDDLE, MAIDEN)

PREVIOUS OR OTHER NAME(S)

2. PRIMARY RESIDENCE (WHERE YOU VOTE, PAY FEDERAL TAXES, OBTAIN A DRIVERS LICENSE) - PHYSICAL ADDRESS REQUIRED, **PO BOXES ARE NOT ACCEPTABLE**

CITY | STATE | ZIP CODE

MAILING ADDRESS (IF DIFFERENT THAN PRIMARY RESIDENCE) STREET OR PO BOX

CITY | STATE | ZIP CODE

3. DATE OF BIRTH — MONTH | DAY | YEAR

PLACE OF BIRTH (CITY) (STATE) (COUNTY)

MOTHER'S MAIDEN LAST NAME

4. **SOCIAL SECURITY NUMBER (MANDATORY, USED FOR IDENTIFICATION PURPOSES ONLY)

TELEPHONE NUMBER - HOME

TELEPHONE NUMBER - WORK

5. INTERNET E-MAIL ADDRESS (PLEASE PRINT)

FAX NUMBER (OPTIONAL)

6. MISSOURI REGISTERED PROFESSIONAL NURSE LICENSE NUMBER ▶

OR

*STATE OF RESIDENCE MULTI-STATE LICENSE NUMBER

7. ARE YOU CURRENTLY OR HAVE YOU EVER PRACTICED, REPRESENTED, OR DESIGNATED YOURSELF AS A NURSE ANESTHETIST, NURSE MIDWIFE, NURSE PRACTITIONER, OR CLINICAL NURSE SPECIALIST IN MISSOURI?

☐ NO ☐ YES

IF YES, PROVIDE A NOTARIZED STATEMENT INDICATING TITLE USED, PRACTICE DATES (BEGINNING, ENDING) AND PRACTICE LOCATION(S).

8. HAVE YOU EVER **APPLIED** TO BE RECOGNIZED AS ELIGIBLE TO PRACTICE AS AND USE TITLES OF A NURSE ANESTHETIST, NURSE MIDWIFE, NURSE PRACTITIONER, OR CLINICAL NURSE SPECIALIST BY THE MISSOURI STATE BOARD OF NURSING?

☐ YES, YEAR _____ ☐ NO If yes, as what? _____

9. HAVE YOU EVER BEEN **RECOGNIZED** AS ELIGIBLE TO PRACTICE AS AND USE TITLES OF A NURSE ANESTHETIST, NURSE MIDWIFE, NURSE PRACTITIONER, OR CLINICAL NURSE SPECIALIST BY THE MISSOURI STATE BOARD OF NURSING?

☐ YES, YEAR _____ ☐ NO If yes, as what? _____

***Primary State of residence** means the State of a person's declared fixed permanent and principal home for legal purposes; domicile. The following items could be requested as proof of primary state of residence; driver's license, voter registration card, federal income tax return.

NOTE: **You must provide your social security number pursuant to state and federal law.**
If you fail or refuse to provide your social security number, we will consider your initial application or renewal application incomplete and return it to you. Continued failure or refusal to provide your social security number is grounds for denial of your application.

SECTION II - ADVANCED PRACTICE NURSE EDUCATION

NAME & ADDRESS OF ADVANCED PRACTICE PROGRAM	OFFICIAL DATE OF COMPLETION	TYPE OF PROGRAM	OFFICIAL DESIGNATED MAJOR OR CLINICAL SPECIALTY	TYPE OF DEGREE AWARDED
		☐ Nurse Anesthetist ☐ Nurse Midwife ☐ Nurse Practitioner ☐ Clinical Nurse Specialist ☐ Other (Please explain) _____		☐ Certificate ☐ Masters/Nursing ☐ Masters/Other ☐ PhD/Nursing ☐ PhD/Other ☐ Other (Please explain) _____
		☐ Nurse Anesthetist ☐ Nurse Midwife ☐ Nurse Practitioner ☐ Clinical Nurse Specialist ☐ Other (Please explain) _____		☐ Certificate ☐ Masters/Nursing ☐ Masters/Other ☐ PhD/Nursing ☐ PhD/Other ☐ Other (Please explain) _____

SECTION III - CLINICAL NURSING SPECIALTY AREA — ALL APPLICANTS

Indicate advanced practice registered nursing category and area of clinical nursing specialty for which you are applying.

ADVANCED PRACTICE REGISTERED NURSE CATEGORY	CLINICAL NURSING SPECIALTY AREA	
☐ Nurse Anesthetist		
☐ Nurse Midwife		
☐ Nurse Practitioner	☐ Acute Care ☐ Adult ☐ Family ☐ Gerontological ☐ Neonatal	☐ Women's Health ☐ Pediatric ☐ School ☐ Other (Please explain in a separate sheet of paper)
☐ Clinical Nurse Specialist	☐ Adult Health ☐ Adult Psychiatric and Mental Health ☐ Advanced Oncology ☐ Child/Adolescent Psychiatric and Mental Health	☐ Gerontological ☐ Home Health ☐ Women's Health ☐ Other (Please explain in a separate sheet of paper)

SECTION IV - SPECIALTY CERTIFICATION HELD OR APPLIED FOR

NAME OF NATIONALLY RECOGNIZED CERTIFYING BODY	EXAMINATION DATE	CERTIFICATION NUMBER	CERTIFICATION EXPIRATION DATE	STATUS
				☐ Exam Applicant ☐ Current ☐ Provisional/Conditional ☐ Other (Please explain) _____
				☐ Exam Applicant ☐ Current ☐ Provisional/Conditional ☐ Other (Please explain) _____

Data provided below is **voluntary** and is not required in order to submit an Application for Recognition. This data will assist the department in nurse demographics. **PLEASE PRINT IN BLACK INK.**

GENDER
☐ FEMALE ☐ MALE

RACE/ETHNIC GROUP
☐ CAUCASIAN (WHITE) ☐ AFRICAN-AMERICAN ☐ HISPANIC ☐ AMERICAN INDIAN/ALASKAN NATIVE
☐ ASIAN/PACIFIC ISLANDER ☐ OTHER (if other, please indicate)_____

NATIONALITY
☐ AMERICAN ☐ FOREIGN (please indicate) _____

LANGUAGE
☐ ENGLISH ☐ FOREIGN (please indicate) _____

CITIZENSHIP
☐ UNITED STATES ☐ FOREIGN (please indicate) _____

SECTION V - SCREENING QUESTIONS

1. Have you ever been issued any professional license, certification, registration, or permit by any state, United States, territory, province or foreign country other than the licenses listed above? ☐ YES ☐ NO
   IF YES, IDENTIFY TYPE OF LICENSE, WHEN ISSUED AND BY WHOM.
2. Have you ever been denied a professional license, certification, registration or permit? ☐ YES ☐ NO
   IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT.
3. Have you ever had any professional license, certification, registration, or permit revoked, suspended, placed on probation, or otherwise subject to any type of disciplinary action? ☐ YES ☐ NO
   IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT.
4. Are you presently being investigated or is any disciplinary action pending against any professional license, certification, registration, or permit you hold? ☐ YES ☐ NO
   IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT.
5. Have you ever voluntarily surrendered or resigned any professional license, certification, registration or permit? ☐ YES ☐ NO
   IF YES, EXPLAIN FULLY IN A SEPARATE NOTARIZED STATEMENT.

SECTION VI - AFFIDAVIT (TO BE NOTARIZED BY A NOTARY PUBLIC) — ALL APPLICANTS

I am aware that all documents needed for recognition as eligible to practice as and use titles of an advanced practice registered nurse must be received in the Board office before my application expires. I am also aware that it is my legal and professional responsibility to inquire at the Board office before my application expires regarding the status of my application. Application fees are non-refundable.

I realize that I cannot practice as nor use titles of an advanced practice registered nurse without a current Missouri OR another Compact State RN license, certification and Board recognition.

I understand that my application for recognition will not be approved if I fail to provide any of the required documentation or information.

Being duly sworn, I state that I am the person who is referred to in the foregoing application for eligibility to practice as and use titles of an advanced practice registered nurse in the State of Missouri; that the statements therein are strictly true in every respect; that I have complied with all requirements of the law; and that I have read and understand this affidavit.

MUST BE SIGNED IN PRESENCE OF NOTARY ▸			
NOTARY PUBLIC EMBOSSER SEAL	STATE		COUNTY (OR CITY OF ST. LOUIS)
	SUBSCRIBED AND SWORN BEFORE ME, THIS DAY OF YEAR		**USE RUBBER STAMP IN CLEAR AREA BELOW.**
	NOTARY PUBLIC SIGNATURE	MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)		

NAME: _____
(LAST, FIRST, MIDDLE INITIAL)

	ITEM	REC'D	PROC'D	INIT
	REQUEST			
	FEE			
	APPLICATION			
	RN LICENSE			
NONCERTIFIED GRADUATE				
	EXAMINATION DOCUMENT			
	EXAM DATE NOTARIZED STATEMENT			
	TRANSCRIPT-MASTERS			
	TRANSCRIPT-POST MASTERS			
	TRANSCRIPT-CERTIFICATE			
	TRANSCRIPT-OTHER			
	OTHER			
CERTIFIED				
	EXAMINATION RESULTS			
	EXAMINATION RESULTS-RETEST			
	EXAMINATION RESULTS-RETEST			
	CERTIFICATION CARD/WALL CERT			
	CONSENT TO RELEASE FORM			
	OTHER			
NONCERTIFIED				
	NONCERTIFICATION EVIDENCE			
	CLINICAL HOURS			
	PHARMACOLOGY EVIDENCE			
	TRANSCRIPT-MASTERS			
	TRANSCRIPT-POST MASTERS			
	TRANSCRIPT-CERTIFICATE			
	TRANSCRIPT-OTHER			
	TRANSCRIPT CLARITY			
	TRANSCRIPT CLARITY			
	OTHER			
FINAL APPROVAL				

COMMENTS

☐ NEVER RECOGNIZED ☐ EXPIRED RECOGNITION ☐ PRACTICE WITHOUT RECOGNITION

FOR OFFICE USE ONLY **DO NOT WRITE ON THIS PAGE**

NAME (LAST, FIRST, MIDDLE INITIAL)

MAIDEN AND/OR PREVIOUS NAMES

RN LICENSE NUMBER

RN EXP

TSRP

DATE/INIT

STATE OF MISSOURI
DIVISION OF PROFESSIONAL REGISTRATION

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

PRINT LEGIBLY IN BLACK INK

I, _____ , hereby authorize the MISSOURI STATE BOARD OF NURSING to release my social security number, in addition to any public information contained in my file at the MISSOURI STATE BOARD OF NURSING, regarding my licensure and application status as a Registered Professional Nurse/Advanced Practice Nurse to my national certifying body/bodies, _____ and/or their representatives, in order to facilitate interagency communication and retrieval of certification or recertification evidence.

A photostatic copy of this authorization will be considered as effective and valid as the original.

APPLICANT'S SIGNATURE	DATE

APPLICANT'S PRINTED NAME

APPLICANT'S SOCIAL SECURITY NUMBER